RCT on the Management of Early Pregnancy Failure

INTERVIEW FOR SYMPTOMS

Site			Patient No.			Letter Code		Visit	

A. INTERVIEW FOR SYMPTOMS

1. Interview date: ___ ___ ___ - ___ ___ - 2 0 0 ___ (Month / Day / Year) FM07DT

1A. Interview done (1) Yes (2) No INTDONE

IF NOT DONE, SKIP TO SECTION B.

Since your last scheduled visit, which was ___ ___days ago, have you experienced the following symptoms? SYDYSAGO

	Symptoms	A Did you have …?		B Was the symptom? SV			C Did you go to see a doctor or nurse for this symptom other than the scheduled study visit? MD		D Did you take any medicine or receive any treatment for this symptom? If (2) , (3), or (4) then complete medication section. MED				
		Yes	No	Mild	Moderate	Severe	Yes	No	None	*Pills provided by Study	*Pills bought by Patient	Both Study and Patient	Other
SYVB	2. Vaginal bleeding	(1)	(2)	(1)	(2)	(3)	(1)	(2)	(1)	(2)	(3)	(4)	(5)
SYTISSUE	3. Passage of tissue	(1)	(2)	(1)	(2)	(3)	(1)	(2)					
SYABPAIN	4. Lower abdominal cramping pain	(1)	(2)	(1)	(2)	(3)	(1)	(2)	(1)	(2)	(3)	(4)	(5)
SYCHILLS	5. Chills	(1)	(2)	(1)	(2)	(3)	(1)	(2)	(1)	(2)	(3)	(4)	(5)
SYFEVER	6. Fever	(1)	(2)	(1)	(2)	(3)	(1)	(2)	(1)	(2)	(3)	(4)	(5)
SYNAUS	7. Nausea	(1)	(2)	(1)	(2)	(3)	(1)	(2)	(1)	(2)	(3)	(4)	(5)
SYVOMIT	8. Vomiting	(1)	(2)	(1)	(2)	(3)	(1)	(2)	(1)	(2)	(3)	(4)	(5)
SYDIAR	9. Diarrhea	(1)	(2)	(1)	(2)	(3)	(1)	(2)	(1)	(2)	(3)	(4)	(5)
SYTIRED	10. Tiredness	(1)	(2)	(1)	(2)	(3)	(1)	(2)	(1)	(2)	(3)	(4)	(5)
SYLTHEAD	11. Lightheadedness/ Dizziness	(1)	(2)	(1)	(2)	(3)	(1)	(2)	(1)	(2)	(3)	(4)	(5)
SYFAINT	12. Fainting	(1)	(2)	(1)	(2)	(3)	(1)	(2)	(1)	(2)	(3)	(4)	(5)
SYHDACHE	13. Headaches	(1)	(2)	(1)	(2)	(3)	(1)	(2)	(1)	(2)	(3)	(4)	(5)

14. List all medication taken since your last scheduled contact. Include pills provided by the study. MEDLIST

Sequence	A. Medication	B. Reason	C. Date of Last Dose Month Day Year
__ __ SEQNO	Code:__ __ _MEDCODE Specify: ________________ MEDSP Dose: ________________ MEDDOSSP	MEDREASP	__ __ __ - __ __ - __ __ __ __ LSTDSEDT
__ __	Code: __ __ Specify: ____________________ Dose: ____________________		__ __ __ - __ __ - __ __ __ __
__ __	Code: __ __ Specify: ____________________ Dose: ____________________		__ __ __ - __ __ - __ __ __ __
__ __	Code: __ __ Specify: ____________________ Dose: ____________________		__ __ __ - __ __ - __ __ __ __
__ __	Code: __ __ Specify: ____________________ Dose: ____________________		__ __ __ - __ __ - __ __ __ __
__ __	Code: __ __ Specify: ____________________ Dose: ____________________		__ __ __ - __ __ - __ __ __ __
__ __	Code: __ __ Specify: ____________________ Dose: ____________________		__ __ __ - __ __ - __ __ __ __

Codes 01 NSAID 02 Other pain medication 03 Antibiotic 04 Other

		YES	NO	
15.	Since your last visit, have you had any other symptoms that are bothering you?	(1)	(2)	SYOTH
	If Yes, Specify _____			SYOTH_SP
16.	Since your last visit, have you gone to see a doctor or nurse other than anyone in this clinic for any reasons?	(1)	(2)	MDVISIT

IF YES, ANSWER ITEMS A AND B AND COMPLETE UNSCHEDULED VISIT MEPF FORM 10.

A. For what reason? _____ MDREASSP

B. What treatment did you receive? _____ MDTRTSP

17.	A.	Since last visit, how many times have you had vaginal sex?	___ ___ Times	VSEXVST
	B.	How many times did you use condoms?	___ ___ Times	CONDMVST
18.		Since last visit, how many times have you douched?	___ ___ Times	DOUCHVST

B. ADMINISTRATIVE MATTERS

GEN_CMNT

1. Comments: _____

CERT_SIG CERT_NO

2. Person completing form: _____ Staff Number: __ __ __ - __ __ __

3. Date form completed: ___ ___ ___ - ___ ___ - 2 0 0 ___ COMPL_DT
Month Day Year